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DAVID E. JANSSEN
Chief Administrative Officer

July 18, 2003

To: Supervisor Yvonne Brathwaite Burke, Chair
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

FEDERAL LEGISLATIVE UPDATE

House Investigation of Hospital Billing Disparities

On July 16, 2003, the House Energy and Commerce Committee sent the attached letter to health care providers, including the Los Angeles County Department of Health Services (DHS), seeking information on hospital billing practices. The Committee's request is related to concerns about billing practices that result in uninsured patients receiving bills that are higher than those received by third-party payers, such as Medicaid. The Committee chose a cross-section of large health systems to respond to their questions, and DHS will be preparing a response to this request.

The Committee's request is one of a number generated in recent weeks about the health care industry and Medicaid. In June, the Committee sent letters to states seeking information about efforts to generate "excessive" Medicaid financing mechanisms, and letters to pharmaceutical manufacturers requesting information about drug pricing and Medicaid costs.

We will continue to keep you advised of any new developments.

DEJ:GK
MAL:JF:ib

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
All Department Heads
Legislative Strategist

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Attachment

Committee News Release

The Committee on Energy and Commerce
W.J. "Billy" Tauzin, Chairman

Tauzin, Greenwood Investigate Hospital Billing Disparities for the Uninsured

WASHINGTON (July 16) --As part of an investigation into the billing inequalities many uninsured patients face during hospital visits, House Energy and Commerce Committee Chairman Billy Tauzin (R-LA) and Oversight and Investigations Subcommittee Chairman James Greenwood (R-PA) today sent letters to the following medical providers:

Adventist Health, Roseville, CA;
Ascension Health, Inc., St. Louis, MO;
Catholic Healthcare Partners, Cincinnati, OH;
Catholic Health East, Newtown Square, PA;
Catholic Health Initiatives, Denver, CO;
Catholic Health West, San Francisco, CA;
HCA, Nashville, TN;
Los Angeles County Department of Health Services, Los Angeles, CA;
Marian Health Systems, Tulsa, OK;
Mayo Health Systems, Rochester, MN;
New York-Presbyterian, New York, NY;
NYC Health and Hospitals Corporation, New York, NY;
North Shore Long Island Jewish Health System, Great Neck, NY;
Providence Health System, Seattle, WA;
Sutter Health, Sacramento, CA;
Tenet, Santa Barbara, CA;
Triad Hospitals, Inc., Plano, TX;
Trinity Health, Novi, MI;
UC Davis Health System, Sacramento, CA;
Universal Health Services, King of Prussia, PA.

July 16, 2003

Dear _____:

The Committee on Energy and Commerce is conducting an investigation into the billing practices of certain medical providers under which the uninsured are expected to pay substantially higher amounts for medical services than third-party health plans such as medical insurers, health maintenance organizations, and preferred provider organizations (collectively, "third-party health plans"), or government health care programs. These practices raise significant public health and consumer protection issues. The uninsured seem caught in the middle of the sophisticated and complicated forces driving health care financing including government entitlements, managed care, rising costs and shrinking public funds. The Committee is approaching your hospital system, as well as other large acute care hospital systems, to obtain further information about these issues.

We understand that medical providers commonly interpret Federal law to require the establishment of uniform charge master lists setting forth rates for each of their services. Yet, based on the Committee's preliminary investigation, these rates are often inflated far beyond their actual costs and reasonable profit due, in part, by the providers' need to make up for the steep discounts from charge master prices demanded by the third-party health plans. For example, according to the U.S. Department of Health and Human Services, California urban hospitals in 2002 averaged a 304.8% mark-up over actual costs in their master charge list prices. While the third-party health plans have bargained to pay far less than these retail charges, individual uninsured patients are expected to pay this full, undiscounted, "sticker" price.

This pricing system also may have other unintended and undesirable consequences. Because these "self-pay" individuals receive bills much higher than other patients for the exact same services, medical providers may be generating a disproportionate share of profit from this relatively small group of patients. Data published for the first time by the California Office of Statewide Health Planning and Development, which is part of the California Health and Human Services Agency, suggests that the 2001 net revenue of one hospital chain in that State, for its self-pay, uninsured and walk-in patients - who, as a whole, accounted for less than 2% of the chain's total patient population - accounted for as much as 35% of the chain's total profits in that State.

Further, while we recognize that Federal law also directs providers to seek full payment on all medical bills, we are concerned that the current system may give incentives to providers not to work with patients in developing payment plans and other structured arrangements.

In this regard, pursuant to Rules X and XI of the U.S. House of Representatives, please provide the Committee with the following records and information by July 31, 2003. For the purpose of responding to these requests, please observe the following definitions: "you" or "your system" means both your parent system as well as individually each acute care hospital within this system; "self-pay" means any patient who (1) has no applicable coverage through a third-party health plan, (2) is not enrolled or eligible for any government-sponsored program such as Medicare, Medicaid, or state or county indigent care, and (3) is not eligible for charity care; "elective procedure" means any medical care sought only for aesthetic or physical enhancement such as cosmetic surgery or eye correction but not including reconstruction or any such procedure recommended by a medical provider for rehabilitation or health reasons; "uninsured" means any self-pay patient not undergoing an elective procedure; "charity care" means any financial assistance or gift, from any source, which directly covers all or part of an individual patient's medical expenses submitted to that patient for payment but not mean any general payments to you for the indirect benefit of patients in the form of facilities or other such overhead; and "payment planning assistance" means any type of counseling or assistance to schedule, structure or tailor the payment of medical accounts based on the financial circumstances of a particular patient.

Please note that Requests No. 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 14, and 20 ask for narrative responses or a statement of specific data. The breadth and timeliness of this investigation require you to prepare and submit complete written responses, as appropriate. To avoid any doubt, answers by way of simple reference to produced documents will be considered insufficient and incomplete for the purposes of this investigation.

Finally, for the purposes of these requests, please do not provide any patient names or patient specific or individually identifiable health information. Also, with respect to questions regarding matters of billing, payment or collection, please do not produce any records which relate only to the accounts of individual, specific patients.

1. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information for each acute care hospital within your system, using the format of the chart below.
    a. Net operating income;
    b. Total patient days;
    c. Net revenue collected per patient day from;
        i. Fee-for-service Medicare
        ii. Medicare+Choice

d. Net revenue collected per patient day from;
    i. Fee-for-service Medicaid
    ii. Managed Medicaid
e. Net revenue collected per patient day from third-party payors from;
    i. i. Traditional insurance
    ii. ii. Managed care insurance
f. For uninsured patients.
    i. Net revenue collected per patient day
    ii. Gross billing per patient day
    iii. Number of patient days for uninsured patients.

2. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information, in aggregate, for your system nationally, using the format of the chart above in Request No. 1.
    a. Net operating income;
    b. Total patient days;
    c. Net revenue collected per patient day from:
        i. Fee-for-service Medicare ii. Medicare+Choice
    d. Net revenue collected per patient day from;
        i. Fee-for-service Medicaid ii. Managed Medicaid
    e. Net revenue collected per patient day from third-party payors from:
        i. Traditional insurance
        ii. Managed care insurance
    f. For the uninsured:
        i. Net revenue collected per patient day
        ii. Gross billing per patient day iii. Number of patient days for uninsured patients.
3. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information, in aggregate, for your system in each State in which you provide acute care hospital medical services, using the format of the chart above in Request No. 1.
    a. Net operating income;
    b. Total patient days;
    c. Net revenue collected per patient day from:
        i. Fee-for-service Medicare
        ii. Medicare+Choice
    d. New revenue collected per patient day from;
        i. Fee-for-service Medicaid
        ii. Managed Medicaid
    e. Net revenue collected per patient day from third-party payors from:
        i. Traditional insurance
        ii. Managed care insurance
    f. For the uninsured:

i. Net revenue collected per patient day

ii. Gross billing per patient day iii. Number of patient days for uninsured patients.

4. 4. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following information for each acute care hospital within your system, using the format of the chart below.
   a. The total gross revenue from uninsured patients
   b. The total net revenue from uninsured patients
   c. The total net revenue collected from uninsured patients
      i. i. under any payment planning assistance program
      ii. ii. through involuntary means such as debt collection
   d. For the deductions from uninsured revenue (gross revenue less net revenue) state:
      i. the total deductions from revenue
      ii. the amount claimed or otherwise identified bad debt
      iii. the amount of such bad debt recovered in any way through any state or federal fund, pool or resource iv. the amount of deductions from revenue claimed or otherwise identified as charity care
5. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide the following for each acute care hospital in your system:
   a. the total disproportionate share hospital ("DSH") payment received; and b. whether the value of any bad debt or otherwise uncompensated services delivered to the uninsured formed any part of the basis or demonstrated need upon which the DSH payments under Medicaid and Medicare, were calculated and, if so, provide the value of such bad debt or services.
6. 6. For the period beginning January 1, 1998, please state each source through which your system received any funds for bad debt or charity care on services provided to the uninsured.
   a. Please state whether line item charges in individual patient bills have ever been earmarked for bad debt pools, charity care pools, or any other such resource or state or local administered fund. If so, please describe this policy, practice or procedure.
7. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide, in chart format, the operating cost-to-charge ratios for the following:
   a. Each acute care hospital within your system;
   b. In aggregate, your system nationally; and
   c. In aggregate, your system in each State in which you provide acute care hospital medical services.

   Please provide unaudited numbers where audited numbers are not yet available.
8. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please provide, in chart format, the following for each acute care hospital within your system:
   a. the ten most billed (in terms of total gross charges) diagnostic related group codes of your system and the cost-to-charge ratio for each such code;
   b. the ten most billed (in terms of total gross charges) ambulatory payment classification codes of your system and the cost-to-charge ratio for each such code;
   c. the three revenue centers and/or profit centers with the lowest cost to charge ratios providing, as well, the relevant ratios.
9. For the period beginning January 1, 1998, to the present, please provide all records relating to any discussions, comparisons or analyses regarding differences between the payments made for medical services by uninsured patients and those paid by third-party health plans or government health care programs.
10. For the period beginning January 1, 1998, to the present, please provide all records relating to rates of collection or realization on bills from self-pay or uninsured patients.

11. Please state how your system identifies uninsured patients who are eligible for any charity care or payment planning assistance. Please also state how such eligible patients are notified of the availability of such charity care or payment planning assistance. Please describe any substantive changes or enhancements to the policies, procedures or practices relating to the eligibility, notification of availability and delivery (in terms of crediting the accounts of eligible patients) of charity care or payment planning assistance since January 1, 1998, including specific dates on which any such changes or enhancements came, or will come, into effect.
12. For the period beginning January 1, 1998, to the present, please provide all records relating to the eligibility, notification of availability and delivery (in terms of crediting the accounts of eligible patients) of charity care and payment planning assistance offered by your system.
13. Please describe any formula and/or methodology used to calculate or otherwise establish charge master rates in your system and state whether there have been any changes to such formulas and/or methodologies from January 1, 1998 to the present.
14. Please describe any policies, procedures or practices relating to availability, posting, dissemination, publication or production of your system's charge master rates to the public and/or current or prospective patients. Please also describe any substantive changes or enhancements to such policies, procedures or practices since January 1, 1998, including specific dates on which any such changes or enhancements came, or will come, into effect.
15. For the period beginning January 1, 1998, to the present, please provide all records relating to any policies, procedures or practices relating to availability, posting, dissemination, publication or production of your system's charge master rates to the public and/or current or prospective patients.
16. For the period beginning January 1, 1998, to the present, please provide all records relating to any considered or implemented changes in charge master rates. This request includes, but is not limited to, any studies, reports or recommendations concerning charge masters rates prepared by any third-party or consultant.
17. For the period beginning January 1, 1998, to the present, please provide all records relating to any discussions, comparisons or analyses of whether any proposed, considered or implemented charge master rates or applicable cost-to-charge ratios are consistent with state or federal law.
18. For the period beginning January 1, 1998, to the present, please provide all records relating to any considered or implemented policy, plan, procedure or practice by which you might increase revenue or profit through changing the mix or ratios within your patient population in terms of responsible payor - e.g., Medicare, uninsured, self-pay, or third-party health plans.
19. For the period beginning January 1, 1998, to the present, please provide all records relating to any considered or implemented policy, plan, procedure or practice the intended effect or result of which would be to increase your amount of bad debt from self-pay or uninsured patients.
20. For the period beginning January 1, 1998, and for each subsequent calendar quarter, please describe your policies, practices and procedures relating to outstanding patient bills (including, but not limited to, payment terms, interest rates, and debt collection), and provide all records relating thereto (including, but not limited to, all records relating to the use of collection agents and under what circumstances matters would be referred to such agents).

Please note that, for the purpose of responding to these requests, the terms "records" and "relating" should be interpreted in accordance with the attachment to this letter. If you have any questions, please contact Mark Paoletta, Chief Counsel for Oversight and Investigations, at (202) 225-2927 or Anthony M. Cooke, Majority Counsel for Oversight and Investigations, at (202) 226-2424.

Sincerely,

W.J. "Billy" Tauzin
Chairman

James C. Greenwood, Chairman
Subcommittee on Oversight & Investigations

cc:

The Honorable John D. Dingell, Ranking Member
The Honorable Peter Deutsch, Ranking Member
Subcommittee on Oversight & Investigations

Related Documents

Oversight and Investigation

Health

Contact: Ken Johnson
202.225.5735

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Feedback